



## Complete Summary

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### GUIDELINE TITLE

Dementia.

### BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 2005. 28 p. [20 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 1998. 32 p.

### \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

On April 12, 2005, the U.S. Food and Drug Administration (FDA) issued a public health advisory to alert health care providers, patients, and patient caregivers to new safety information concerning an unapproved, "off-label" use of certain antipsychotic drugs approved for the treatment of schizophrenia and mania. FDA has determined that the treatment of behavioral disorders in elderly patients with dementia with atypical (second generation) antipsychotic medications is associated with increased mortality. Clinical studies of these drugs in this population have shown a higher death rate associated with their use compared to patients receiving a placebo. See the [FDA Web site](#) for more information.

### COMPLETE SUMMARY CONTENT

#### \*\* REGULATORY ALERT \*\*

#### SCOPE

#### METHODOLOGY - including Rating Scheme and Cost Analysis

#### RECOMMENDATIONS

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#### IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT  
CATEGORIES  
IDENTIFYING INFORMATION AND AVAILABILITY  
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Dementia

GUIDELINE CATEGORY

Diagnosis  
Evaluation  
Management  
Treatment

CLINICAL SPECIALTY

Geriatrics

INTENDED USERS

Advanced Practice Nurses  
Allied Health Personnel  
Nurses  
Pharmacists  
Physicians  
Social Workers

GUIDELINE OBJECTIVE(S)

- To offer care providers and practitioners in long-term care facilities a systematic approach to recognizing, assessing, treating, and monitoring patients with dementia, including impaired cognition and problematic behavior
- To help practitioners to provide dementia patients with a systematic assessment and care plan, leading to appropriate management that maximizes functioning and quality of life and minimizes the likelihood of complications and functional decline

TARGET POPULATION

Elderly individuals and/or residents of long-term care facilities who have, or are suspected of having, dementia

INTERVENTIONS AND PRACTICES CONSIDERED

Recognition/Assessment

1. Review patient history
2. Evaluate signs and symptoms
3. Perform diagnostic work-up, if appropriate
4. Determine if patient meets criteria for dementia
5. Identify cause of dementia, if possible
6. Identify patient's strengths and deficits
7. Define the significance of patient's symptoms, impairments, and deficits
8. Identify triggers for disruptive behavior

## Treatment

1. Prepare interdisciplinary care plan
2. Optimize function and quality of life and capitalize on remaining strengths
  - Consider using complementary & alternative therapies
  - Prevent excess disability
  - Consider medical interventions if appropriate
3. Address socially unacceptable or disruptive behaviors, using both non-pharmacological and pharmacological interventions
4. Manage functional deficits
5. Address pertinent psychosocial and family issues
6. Address related ethical issues
7. Manage risks and complications related to dementia, other conditions, or treatments

## Monitoring

Monitor the patient's progress and adjust management as appropriate

## MAJOR OUTCOMES CONSIDERED

- Level of functioning:
  - Functional assessment measures such as the Activities of Daily Living (ADL) portion of the Minimum Data Set (MDS), the Barthel Index, or the Functional Activities Questionnaire (FAQ)
  - Cognitive function assessment measures such as the Mini-Mental State Examination (MMSE), the Clock Drawing test, the Blessed Orientation Memory-Concentration Test, or other comparable instruments
- Signs and symptoms of dementia
- Quality of life
- Complications and functional decline

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

#### METHODS USED TO ANALYZE THE EVIDENCE

Review

#### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

#### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

#### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This guideline was developed by an interdisciplinary workgroup, using a process that combined evidence and consensus-based approaches. The Workgroup included practitioners and others involved in patient care in long-term care facilities. Beginning with a general guideline developed by an agency, association, or organization such as the Agency for Healthcare Research and Quality (AHRQ), pertinent articles and information, and a draft outline, each group worked to make a concise, usable guideline tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

#### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

#### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

#### METHOD OF GUIDELINE VALIDATION

External Peer Review  
Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Guideline revisions were completed under the direction of the Clinical Practice Guideline Steering Committee. The committee incorporated information published in peer-reviewed journals after the original guidelines appeared, as well as comments and recommendations not only from experts in the field addressed by the guideline but also from "hands-on" long-term care practitioners and staff.

All American Medical Directors Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The algorithm [Dementia](#) is to be used in conjunction with the clinical practice guideline. The numbers next to the different components of the algorithm correspond with the steps in the text. Refer to the "Guideline Availability" field for information on obtaining the full text guideline.

### CLINICAL ALGORITHM(S)

A clinical algorithm is provided for [Dementia](#).

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

The guideline was developed by an interdisciplinary workgroup, using a process that combined evidence- and consensus-based approaches. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Expected Outcomes from Implementation of this Clinical Practice Guideline

Implementation of this guideline should:

- Identify patients who are at risk for new or progressive dementia
- Identify the nature and causes of dementia in different patients
- Make appropriate environmental modifications to maximize patient dignity, comfort and safety
- Identify and manage potential sources of excess disability
- Minimize preventable complications and functional decline
- Manage dementia symptoms, consequences, and complications effectively and appropriately
- Respond appropriately to the changing needs of patients with dementia

Anticipated care outcomes: As a result of the above, the following patient-related outcomes may be anticipated:

- Maintained or improved function and quality of life prior to the end of life
- Reduced complications and negative consequences of the condition or its management
- Improved resource utilization

#### POTENTIAL HARMS

- Examples of complications from medical treatment of problematic behavior:
  - Adverse reactions to medication
  - Worsening of disruptive or socially unacceptable behavior
  - Increased lethargy or confusion
  - Cardiac arrhythmias
  - Orthostatic hypotension

### QUALIFYING STATEMENTS

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- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association, its heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of the American Medical Directors Association's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and caregivers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinician's ability to practice.

### IMPLEMENTATION OF THE GUIDELINE

#### DESCRIPTION OF IMPLEMENTATION STRATEGY

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

- I. Recognition
  - Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG
- II. Assessment
  - Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes
- III. Implementation
  - Identify and document how each step of the CPG will be carried out and develop an implementation timetable
  - Identify individual responsible for each step of the CPG
  - Identify support systems that impact the direct care
  - Educate and train appropriate individuals in specific CPG implementation and then implement the CPG
- IV. Monitoring
  - Evaluate performance based on relevant indicators and identify areas for improvement
  - Evaluate the predefined performance measures and obtain and provide feedback

## IMPLEMENTATION TOOLS

Clinical Algorithm  
Tool Kits

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 2005. 28 p. [20 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1998 (revised 2005)

### GUIDELINE DEVELOPER(S)

American Medical Directors Association - Professional Association

### GUIDELINE DEVELOPER COMMENT

Organizational participants included:

- American Association of Homes and Services for the Aging
- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- National Association of Directors of Nursing Administration in Long-Term Care
- National Association of Geriatric Nursing Assistants
- National Conference of Gerontological Nurse Practitioners

### SOURCE(S) OF FUNDING

Funding was provided by educational grants through Bayer Pharmaceuticals, Eisai, Inc./Pfizer, Eli Lilly & Company, Merck & Company, Novartis Pharmaceuticals, Parke-Davis, and Wyeth-Ayerst Laboratories.

### GUIDELINE COMMITTEE

Steering Committee

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Marjorie Berleth, MSHA, RNC, FADONA; Susan M. Levy, MD, CMD; Lisa Cantrell, RN, C; Harlan Martin, RPh, CCP, FASCP; Charles Cefalu, MD, MS; Geri Mendelson, RN, CNAA, MEd, NHA; Sherrie Dornberger, RNC, FADONA; Evvie F. Munley; Sandra Fitzler, RN; Jonathan Musher, MD, CMD; Joseph Gruber, RPh, FASCP, CGP; Mary Tellis-Nayak RN, MSN; Larry Lawhorne, MD, CMD;



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#### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

#### GUIDELINE STATUS

This is the current release of the guideline.

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#### GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: [www.amda.com](http://www.amda.com).

#### AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Guideline implementation: clinical practice guidelines. Columbia, MD: American Medical Directors Association, 1998, 28 p.
- We care: implementing clinical practice guidelines tool kit. Columbia, MD: American Medical Directors Association, 2003.

Electronic copies: None available

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: [www.amda.com](http://www.amda.com)

#### PATIENT RESOURCES

None available

#### NGC STATUS

This summary was completed by ECRI on July 12, 1999. The information was verified by the American Medical Directors Association as of August 8, 1999. This NGC summary was updated by ECRI on August 26, 2005.

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